Provider Manual
Section 11.0
Special Programs

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11.1 Case Management

11.1.1 Definition

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

11.1.2 Target Populations

Enrollees who may benefit from case management are those with ongoing complex medical needs or those at risk for an avoidable adverse outcome/event. The following individuals may warrant case management; however, this listing is not meant to be all-inclusive:

- Individuals at risk for an avoidable outcome/event;
- Children in/or receiving foster care or adoption assistance;
- Blind/disabled children under the age of 19 and related populations eligible for SSI;
- Adults over the age of 65;
- Homeless individuals;
- Individuals with chronic physical health illnesses; and,
- Individuals with chronic behavioral health illnesses.

11.1.2.1 How are Referrals Generated?

Referrals to Case Management may be received through many sources:

- Stratification;
- Enrollee Services line;
- Lighthouse enrollee and provider inquiries;
- Completed Health Risk Assessments (HRAs);
- Recently discharged enrollees from hospitals, or enrollees who have required Emergency Room care;
- Outreach calls by Rapid Response Outreach (RROT) case managers to enrollees who have called the 24-hour Nurse Line and require further assistance from our Case Management staff;
- Internal department referrals; and,
- Providers seeking case management referrals for their patients.

11.1.3 How to Request Case Management Services

Providers, as well as enrollees and other interested parties, may request case management services. Providers may contact the Rapid Response department at 844-243-5176 from 8 a.m. to 8 p.m. EST/ 7 a.m. to 7 p.m. CST to make a case management referral or by completing the Care Coordination Request Form available online at www.lighthousehealthplan.com . If you would like to speak with the case manager once he or she is assigned, notify the Rapid Response coordinator when you make a case management request. Participation in Case Management is voluntary, and the enrollee has the right to decline any or all parts of the program.

11.1.4 Rapid Response Outreach Team

The RROT team was developed at Lighthouse to address enrollees' health questions, to identify enrollees in need of care coordination services, and to address the urgent needs of our enrollees. Lighthouse's goal is to reduce both avoidable emergency room visits and in-patient stays, as well as assist in removing barriers to needed healthcare services.

The team consists of registered nurses and case management technicians (under the direction of the clinical staff), as well as social workers, pharmacists, pharmacy technicians, and durable medical equipment support staff.

11.1.4.1 What We Do

The team members of the Lighthouse RROT are trained to assist in the rapid triage of enrollees' needs. The team assists enrollees in investigating and overcoming the barriers to achieving their health care goals. The RROT can assist with:

- Questions concerning how to obtain supplies or services from Durable Medical providers;
- Transportation scheduling;
- Assisting with pharmacy and barriers to receiving medications;
- Collaborating with specialists;
- Coordination of physician appointments;
- Scheduling preventive health screens;
- Facilitating medication access;
- Informing enrollees of the available community resources, and assisting them in completing the application process and following through of services;
- Outreaching to enrollees for HEDIS® measures; and
- Resources for resolution of legal questions such as the creation of advanced directives, living trusts, or other types of legal assistance.

11.1.4.2 Contact the Rapid Response Outreach Team

The RROT can be reached at 844-243-5176 from 8 a.m. until 8p.m. EST/ 8 a.m. until 8p.m. CST Monday through Friday. After hours, there is a 24-hour Nurse Call Line available to all enrollees at 844-243-5176.

11.2 Health and Disease Management Programs

11.2.1 Introduction

Lighthouse is committed to working with providers to help keep enrollees achieve healthy outcomes by encouraging preventative care and member self-management. One way to do this is through Health and Disease Management programs that ideally prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care. Lighthouse's Health and Disease Management programs include Catastrophic Care, Complex Care, Condition Care, Transition Care, Care Coordination, Maternity, and many others. Providers are informed about the programs through various methods, including Lighthouse's Provider Manual, website, provider communications, New Provider Orientation Kit, office site visits by the Provider Relations Specialists, and face-to-face education visits by the disease-specific provider.

11.2.2 Purpose of Programs

Each program emphasizes education for targeted enrollees and providers to improve the overall health, wellness, and quality of the enrollee's life. The goal of the programs is to provide tools to educate the enrollee on achieing improved health outcomes through education, prevention, detection, treatment, andself-management. These programs aim to facilitate enrollee understanding and self-management of the disease process, as well as the coordination of care between the enrollee and/or caregiver and the provider. Programs focus on increasing both enrollee and provider adherence with well-established and professionally recognized guidelines.

11.2.3 Evaluation of Programs

The objectives, activities, and outcomes of each Health and Disease Management Program are continually evaluated and measured against national standards. Updates and revisions are made as needed, and the programs are reviewed at least annually. Reviews consist of:

- Measuring participation rates;
- Determining whether the programs have demonstrated improvement in outcomes and quality of care provided to enrollees;
- Evaluating the overall effectiveness of the programs;
- Exploring the barriers and limitations of the programs; and
- Revising areas as needed to improve the effectiveness of the programs.

11.2.4 Types of Disease Management Programs

Lighthouse offers the following Disease Management Programs:

- Diabetes;
- Chronic respiratory;
- Congestive heart failure (CHF);
- Asthma; and
- Coronary Artery Disease.

Please reference Lighthouse's website at www.lighthousehealthplan.com for additional program information.

11.2.5 Remote Patient Monitoring Programs

The Plan offers remote patient monitoring for enrollees who meet the criteria for enrollment. Enrollees with a diagnosis of COPD or Asthma may be eligible to participate, if they meet the following criteria:

- COPD Diagnosis and the following:
    - Home Oxygen Use,
    - Daily Nebulizer Use,
    - Red Risk Score for Readmissions,
    - COPD DX plus HTN DX,
    - COPD DX plus two or more medications, or
    - COPD DX plus a BMI greater than or equal to 30

- Asthma Diagnosis and the following:
    - Rescue and Maintenance Inhalers,
    - Daily Nebulizer Use,
    - Red Risk Score for Readmissions,
    - 1 or More Dose of Steroids or Antibiotics in the Past 6 Months,
    - Asthma DX plus HTN DX,
    - Asthma DX plus two or more medications, or
    - Asthma DX plus a BMI greater than or equal to 30

- Exclusion Criteria:
    - Enrollee is physically/cognitively unable to participate and has no caregiver to assist
    - Home environment is not conducive for home monitoring
    - Enrollee/caregiver refuses to participate

- Enrollee weight exceeds scale limit of 440 pounds (consider eligibility for other monitoring)

Eligible enrollees are assigned a Program Coordinator and/or a Care Advisor to guide them through the program and coordinate their program progression with the PCP or ordering physician. Should you want to refer an enrollee for inclusion in a remote monitoring program, please contact our Care Management team at 800-653-7104.

11.3 Telemedicine

Lighthouse is pleased to provide Telemedicine to our enrollees. Please see the telemedicine section of our Provider Portal for more information on how to become a telemedicine provider.

The following items for services provided through telemedicine include:

- A brief explanation of the use of telemedicine in each progress note;
- Documentation of telemedicine equipment used for the particular Covered Services provided;
- A signed statement from the enrollee or the enrollee's representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or a one-time visit, as applicable to the service(s) provided; and
- A review of telemedicine should be included in Lighthouse's fraud and abuse detection activities.